ADULT & PEDIATRIC
ALLERGY & ASTHMA ASSOCIATES

Seth S. Schurman, M.D.

WELCOME TO OUR OFFICE!

Patient Information

Date: _____ Gender: ( ) M ( ) F DOB: _____ Age: _____

Patient's Name: _____
First Middle Last

Address: _____

Home Phone: _____

Occupation: _____ Employer: _____

Work Address: _____

Work Phone: _____

Are You On Medicare? ( ) NO ( ) YES: Medicare #: _____

Social Security #: _____

Marital Status: ( ) married ( ) separated ( ) divorced ( ) single ( ) widow ( ) minor

Spouse's Name: _____

Occupation: _____ Employer: _____

Work Address: _____

Work Phone: _____

For Children
(Please Complete The Following)

Mother's Name: _____

Address: _____

Home Phone: _____

Occupation: _____ Employer: _____

Work Address: _____

Work Phone: _____

Father's Name: _____

Address: _____

Home Phone: _____

Occupation: _____ Employer: _____

Work Address: _____

Work Phone: _____

Person Responsible For Bills: _____

Method Of Payment Today: ( ) cash ( ) check ( ) credit card

If Using Insurance, You Are Responsible For Any Deductible &/or Co-pay on day of service

All HMO/POS Patients Must Have Valid Authorization with Them On The Day of Service!

( ) Primary Care or Referring Physician ( )

Name: _____

Office Address: _____

Office Phone: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Insurance Company: _____

Insured's Name: _____

Birth Date: _____

Insured's Employer: _____

Are You A: ( ) permanent resident: _____# of years ( ) seasonal visitor: _____# of months

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Patient's Responsibility

I Understand That I Am Responsible For Paying For Appointments Not Canceled 24 Hours In Advance!

Signature: _____

Insurance Assignment

I _____ request that "A Adult & Pediatric Allergy & Asthma Associates", apply to my medical insurance carrier on my behalf for payment of all charges incurred. I understand that I must first meet my deductible and any co-payment required by my carrier, as well as pay all charges not fully paid by my insurance company. I further understand that what my insurance company considers reasonable, may fall far short of the actual charges, and that I will be responsible for the difference in costs. I further certify that all charges regarding my medical care have been previously explained in full.

Patient: _____ **Date:** _____

Witness: _____

Medicare Lifetime Authorization

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or it's intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for me.

Patient: _____ **Date:** _____

ADULT & PEDIATRIC
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Patient's Name: _____ DOB: _____
First Middle Last

Personal Medical History

Have you ever had ("✓" ALL THAT APPLY):

( ) Asthma
( ) Hives
( ) Eczema
( ) Frequent Colds
( ) Frequent Sore Throat
( ) Frequent Infections
( ) Pneumonia
( ) Hay Fever

( ) Heart Disease
( ) Rheumatic Fever
( ) High Blood Pressure
( ) Low Blood Pressure
( ) Anemia
( ) Jaundice
( ) Hepatitis: A B C
( ) Pleurisy

( ) Prostate Trouble
( ) Meningitis
( ) Tuberculosis
( ) Gonorrhea/Syphilis
( ) Cancer: _____
( ) Arthritis/ Rheumatism
( ) Frequent Boils
( ) Diabetes

( ) Bone/Joint Disease/Bursitis
( ) Neuritis/Neuralgia/Sciatica
( ) Broken Bones/Broken Nose

( ) Hyperthyroidism (high)
( ) Hypothyroidism (low)
( ) Unconscious/Head Injury

Other Medical Problems (Please List): _____

_____

Medications

Current Medications (Please List Name, Dose & Frequency): _____

_____

Do you use the following Non-Prescription Drugs? ("✓" ALL THAT APPLY):

( ) Vitamins ( ) Antacids ( ) Tylenol
( ) Aspirin/Ibuprofen ( ) Laxatives ( ) Decongestants

Allergy History

Are you allergic to ("✓" ALL THAT APPLY & Describe Reaction):

( ) Penicillin: _____ ( ) Cosmetics: _____

( ) Sulfa Drugs: _____ ( ) Adhesive Tape: _____

( ) Aspirin/Ibuprofen: _____ ( ) Codeine/Narcotics: _____

( ) Any Foods: _____

Other Drugs/Immunization Reactions: _____
Ever stung by a: ( ) Bee ( ) Wasp ( ) Yellow Jacket ( ) Hornet ( ) Fire Ants?

Describe Any Reactions:_____
Localized Reactions Only: ( ) NO ( ) YES

Social/Immunization History

Unusual hobbies/habits: _____

Drink Alcohol? ( ) NO ( ) YES: # of drinks: ___/day ___/month ___/Year
Do you smoke? ( ) Never ( ) In the Past ( ) Now If so, _____ packs/day, for _____ years
Do you use other recreational/non-prescription drugs? ( ) NO ( ) YES:

Frequency: _____

Have you had Tetanus shot/booster in the last 10 years? _____

If so, when? _____

Surgical History

Have you ever had?

Tonsillectomy/Adenoidectomy: ( ) NO ( ) YES
Nose/Sinus Surgery: ( ) NO ( ) YES
Hysterectomy/Ovaries Out: ( ) NO ( ) YES

Other Surgery (Please List): _____

Family Medical History

"✓" Boxes if Yes	*Father*	*Mother*	*Sibling(s)*	*Spouse*	*Children*
Age (if living)					
Health (G) Good (B) Bad					
Cancer					
Tuberculosis					
Diabetes					
Heart Disease					
High Blood Pressure					
Hives					
Asthma					
Hay Fever					
Eczema					
Other (Please List)					
Age (At Death)					
Cause of Death					

Environmental Survey

("✓" & Write-In Appropriate Response):

Dwelling: ( ) House ( ) Apartment ( ) Condo Age of Building: _____ years old
Heating: ( ) Electric/Forced Air ( ) Steam ( ) Baseboard ( ) Radiators ( ) Oil Heat
Flooring: ( ) Carpeted/Minimal Tile ( ) Half Carpet/Half Tile ( ) All Tile/Hardwood
Window Treatments: ( ) Drapes ( ) Vertical Blinds ( ) Horizontal Blinds

( ) Other: _____

Your Bedroom: ( ) Carpeted ( ) Hardwood/Tile ( ) Books ( ) Stuffed Animals ( ) Table Items
Mattress: ( ) Conventional ( ) Waterbed Age: _____ years old
Pillows: ( ) Feather ( ) Synthetic Age: _____ years old

Pets (List): _____ ( ) Indoors ( ) Outdoors
Smokers in home? ( ) NO ( ) YES: # of smokers: _____

Occupation/Specific Work: _____
Symptoms Worse: ( ) At Work ( ) At Home ( ) Can't Tell ( ) Anywhere ( ) Outdoors ( ) Indoors
Anything in or out of home that might be contributing to your symptoms:

_____

_____

Explain Briefly The Main Problems You Are Having & What Brings You In To See Us Today:

_____

_____

FINANCIAL POLICY

Thank you for choosing "A Adult & Pediatric Allergy & Asthma Associates" as your Allergy providers. We are committed to the success of your treatment and care. Please understand that payment of your account is part of the process. The following is our financial policy. Please read the information and let us know immediately if you have any questions regarding the information. Thank you.

Payment Is Expected At The Time Services Are Rendered:

At the time services are rendered, we will collect your co-payment or co-insurance, as well as any balance due from a previous date of service. We accept cash, check, credit card (Visa, MasterCard) and debit cards. Failure to pay your co-payment or co-insurance at the time of service will result in a billing service fee of $10.00.

We participate with Medicare, specific commercial insurance plans and networks. Please ask our office if we participate with your insurance provider. We make every effort to comply with the terms and conditions of the plans with which we do business. However, it is solely your personal responsibility to determine whether your insurance company participates with "A Adult & Pediatric Allergy & Asthma Associates", or with any laboratory, radiology, hospital or other facility at which medical services may be scheduled on your behalf. "A Adult & Pediatric Allergy & Asthma Associates" assumes no financial responsibility for charges related to services rendered at non-participating facilities.

Insurance Claims:

As a courtesy to you, if "A Adult & Pediatric Allergy & Asthma Associates" is a participating provider with your insurance plan, we will file your insurance claim for you. Your insurance company makes the final determination regarding your eligibility and benefits. You agree to pay any portion of the charges that are not covered by your insurance company. If we are not participating with your insurance plan, we may file the initial claim, but, if payment is not received in 45 days, we will transfer the unpaid balance to you and require you to pre-pay for any future services before they are rendered. If your insurance requires a referral or pre-authorization prior to a visit or procedure, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from your insurance company and a higher "out-of-pocket" cost to you.

Returned Checks:
**** We Charge A Fee For All Returned Checks! ****

Past Due Balances:

We will take the necessary steps to collect "past due" balances. If we need to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If your account is referred for legal action, you agree to pay all of the legal fees that we incur plus court costs. In the event of litigation, you agree the venue shall be in Lee County, Florida. You understand that if your account is submitted to an attorney, collection agency, litigated in court, or "past due" status is reported to a credit reporting agency, the fact that you received treatment at "A Adult & Pediatric Allergy & Asthma Associates" will become a matter in the public record.

Appointments:

We understand that unexpected circumstances can sometimes interfere with your scheduled appointments; however, you are responsible for contacting the office to:

***** Cancel your scheduled appointment at least 24 hours before the scheduled service to avoid having a late cancellation fee added to your account. *****

I have read and understand the Financial Policy of "A Adult & Pediatric Allergy & Asthma Associates". I agree to abide by the terms and conditions contained herein. I also acknowledge receiving a copy of this Policy for my records.

_____ ____/_____/_____
PATIENT/PARENT/LEGAL GUARDIAN NAME **DATE**

_____ ____/_____/_____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of "A Adult & Pediatric Allergy & Asthma Associates" Notice of Privacy Practices.

Further, I permit a copy of this authorization to be used in a place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

May we mail to your home, or other designated location, any items that assist the practice in carrying treatment/ healthcare operations, such as appointment reminders, insurance items and lab results?	**( ) YES ( ) NO**
May we leave a message with a member of your household regarding appointments, lab results and insurance?	**( ) YES ( ) NO**
If yes, whom:_____ Relationship:_____ **If yes, whom:_____ Relationship:_____**	
May we leave a message on an answering machine regarding appointments, lab results and insurance?	**( ) YES ( ) NO**
If employed, may we contact you at your work place?	**( ) YES ( ) NO**
I understand the contents of this notice?	**( ) YES ( ) NO**

_____

PATIENT OR LEGAL GUARDIAN SIGNATURE
(IF UNDER 18, PARENT OR LEGAL GUARDIAN SIGNATURE & STATE YOUR RELATIONSHIP TO PATIENT)